U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue date: 20Mar2002

In the Matter of:

EMERSON CHESTER,
Claimant

Case No. 1996-BLA-1075

v.

HI-TOP COAL COMPANY; MULLINS COAL COMPANY OF VIRGINIA, MULLINS #3, INCORPORATED,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party in Interest

Appearances:

Bobby Steve Belcher, Jr., Esq.
Wolfe, Farmer, Williams and Rutherford
For the Claimant

H. Ashby Dickerson, Esq.
PennStuart
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER ON SECOND REMAND AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. (the "Act"). The Act and implementing regulations, 20 CFR parts 410, 718, 725 and

727 (the “Regulations”), provide compensation and other benefits to: (1) living coal miners who are totally disabled due to pneumoconiosis and their dependents; (2) surviving dependents of coal miners whose death was due to pneumoconiosis; and (3) surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death (for claims filed prior to January 1, 1982). The Act and Regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2001). In this case, the Claimant, Emerson Chester, alleges that he is totally disabled by pneumoconiosis.

The case is before me on remand from the Benefits Review Board vacating the decision of another judge. By order dated October 24, 2001, Associate Chief Judge Thomas M. Burke gave the parties 30 days to object to reassignment of the case, and to brief the issues remanded by the Board for consideration. No objections or briefs have been filed. I have therefore considered the case on the record which has already been made.

PROCEDURAL HISTORY

The claimant, Emerson Chester, initially filed a claim for benefits with the Department of Labor on September 5, 1978. On a review of the evidence before him, the District Director, Office of Workers' Compensation Programs ("OWCP"), issued an initial finding of entitlement for a working miner on February 11, 1980. Having apparently not ceased his work as a miner within the prescribed time period, the claimant filed a second claim for benefits on December 18, 1983, which was denied on December 20, 1984. DX 26. The claimant thereafter filed another application for benefits on July 28, 1987, which was withdrawn at the claimant's request on June 1, 1990. DX 27.

The claimant filed the instant duplicate claim for benefits on June 5, 1990. DX 1. By Decision and Order dated July 10, 1992, in which the claimant was credited with thirty-two (32) years of coal mine employment, Administrative Law Judge (“ALJ”) Paul Teitler denied benefits. Applying the Part 718 regulations, Judge Teitler found that the claimant had established the existence of pneumoconiosis arising out of his coal mine employment pursuant to 20 CFR §§718.202(a)(1) and 718.203(b). He found, however, that the claimant failed to establish total respiratory disability pursuant to 20 CFR § 718.204(c) and concluded that the claimant had thus failed under 20 CFR § 725.309(d) to establish a material change in conditions since the denial of his first claim. DX 43. The claimant appealed that decision, and the Benefits Review Board ("the Board") affirmed, as unchallenged on appeal, the findings that the claimant suffered from pneumoconiosis arising out of his coal mine employment. The Board further affirmed Judge Teitler's findings that the evidence was insufficient to establish total disability under §§ 718.204(c)(1)-(3). However, the Board vacated Judge Teitler's findings under § 718.204(c)(4) because he failed to explain his findings regarding physicians’ opinions as to disability, and remanded the case for reconsideration of the medical opinion evidence thereunder. Lastly, the Board vacated Judge Teitler's finding of no material change in conditions pursuant to § 718.309(d). DX 52.

On remand, Judge Teitler again found that the evidence was insufficient to establish total disability under § 718.204(c)(4). Accordingly, benefits were denied on June 14, 1994. DX 58. The claimant timely requested modification of Judge Teitler's Decision and Order and submitted new evidence. DX 60. The OWCP denied the claimant's request, and the case was forwarded for a formal hearing to the Office of Administrative Law Judges ("OALJ").

On October 30, 1996, a hearing was held before ALJ Joan Huddy Rosenzweig. A Decision and Order Denying Petition for Modification and Denying Benefits was issued on May 19, 1998. The claimant appealed that decision, and on September 30, 1999, the Board issued its Decision and Order vacating the May 19, 1998 Decision and remanding the case for further proceedings consistent with its opinion.

On June 22, 2000, Judge Rosenzweig issued a Decision and Order Awarding Benefits on Remand. The employer appealed that decision, and on July 31, 2001, the Board issued another Decision and Order vacating the June 22, 2000 Decision and remanding the case for further proceedings not inconsistent with its opinion.

As Judge Rosenzweig is no longer with this Office, Associate Chief Judge Thomas M. Burke issued an Order on October 24, 2001 allowing the parties thirty days to object to the transference of this case to another ALJ. As no party objected, the case was reassigned to me.

ISSUES

When the Benefits Review Board vacates an ALJ's decision, the decision has been annulled or set aside, "rendering it of no force or effect"; the parties are returned "to the *status quo ante* the . . . decision." *Dale v. Wilder Coal Co.*, 8 B.L.R. 1-119, 1-120 (1985). The issues before me, then, are the issues as they were delineated at the hearing before Judge Rosenzwieg. The issues contested by the Employer are:

1. Whether Emerson Chester has pneumoconiosis as defined by the Act and the Regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

5. Whether the evidence establishes a material change in conditions pursuant to 20 CFR § 725.309 (2000).

6. Whether the evidence establishes a change in conditions or that a mistake was made in the

determination of any fact in Judge Teitler's prior denial (dated June 14, 1994) pursuant to 20 CFR § 725.310 (2000).

DX 80; Transcript, October 30, 1996 ("1996 Tr.") at 5-7.

APPLICABLE STANDARDS

This claim relates to an April 23, 1995, request for modification of an adverse decision on a "duplicate" claim filed on June 5, 1990. Because the claim at issue was filed after April 1, 1980, the Regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2001). Parts 718 (standards for award of benefits) and 725 (procedures) of the Regulations have undergone extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 et seq. (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. *See* 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2001). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding duplicate claims and modification) do not. For a list of the revised sections which do **not** apply to pending cases, see 20 CFR § 725.2(c) (2001). In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2001 edition.

As this is a request for modification of a denial of a duplicate claim, pursuant to 20 CFR § 725.310 (2000), in order to establish that he is entitled to benefits in connection with his current claim, Mr. Chester must demonstrate that there has been a change in conditions or a mistake in a determination of fact such that he meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, Mr. Chester must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2001). I must consider all of the evidence pertaining to his duplicate claim to determine whether there has been a change in conditions or a mistake of fact by ALJ Teitler; new evidence is not required for me to reach a determination that there has been a mistake of fact. *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254 (1971); *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993). Because the underlying claim is a duplicate claim, in order to be entitled to benefits, Mr. Chester would also need to establish a material change in conditions since his previous claim was denied (December 20, 1984). 20 CFR § 725.309(d) (2000); *see Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1363 (4th Cir. 1996).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Emerson Chester was born on March 26, 1928, and has a fifth grade education. DX 1. His wife, Wanda (Edwards) Chester is his only dependent. DX 1, 8, 9. The parties stipulated that the claimant had at least 32 years of coal mine employment. 1996 Tr. at 6. The claimant last worked as a coal miner on July 30, 1990. DX 5; 1996 Tr. at 8; 1991 Tr. (DX 36) at 11. His job for the last year he worked was carrying timbers and hauling rock dust weighing up to 50 pounds, and shoveling head drives and belt drives. 1991 Tr. at 11-12. He quit working when he was 62 because of his health, including shortness of breath and bad knees. 1991 Tr. at 24-27. He used to smoke off and on, having started about age 15 or 16, and quit several years before he retired. At the 1996 hearing, he estimated that he had not smoked for the last 19 years, 1996 Tr. at 9; at the 1991 hearing he said he had not smoked for the last 12 years, 1991 Tr. at 24. His last coal mine employment was in Virginia. DX 2, 4. Therefore this claim is governed by the law of the 4th Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Medical Evidence

The following is a summary of the medical evidence developed after denial of Mr. Chester's second claim and submitted in connection with this duplicate claim filed June 5, 1990.

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2000). All such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, generally given regarding x-rays taken in connection with medical treatment for other conditions, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations. Qualifications of physicians are

abbreviated as follows: A= NIOSH[1] certified A-reader; B= NIOSH certified B-reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
1/23/87	DX 27 HHS Category 1		
3/31/87		DX 27, 26 Felson/BCR, B; Castle/B (0/1,q,p); McCluney/BCR, B (0/0)	DX 27, 26 Wiot/BCR, B; Spitz/BCR, B (Unreadable)
9/16/87	DX 33 Byers/A (2/1, q/t)	DX 27 Wiot/BCR, B; Felson/BCR, B	DX 27 Spitz/BCR, B (Unreadable)
10/7/87	DX 27 Paranthaman/B (1/0, p/q)	DX 27 Wiot/BCR, B; Felson/BCR, B; Spitz/BCR, B	
6/9/88	DX 27 Wiot/BCR, B (1/1, q/q)	DX 27 Stewart/B (0/1,q/t); Felson/BCR, B; Spitz/BCR, B; McCluney/BCR, B (0/0)	
7/17/90	DX 15 Nash/B (1/1, p/p) DX 10 Ramakrishnan/BCR, B (1/0, q); Mathur/BCR, B (1/1, q/r); Pathak/BCR, B (2/2, p/q); Aycoth/BCR, B (1/1, p/q)	DX 29 Wiot/BCR, B (0/1, q/q); Spitz/BCR, B DX 34 Bennett/B (0/1, q/q)	
8/15/90	DX 11 Paranthaman/B (1/0, p/p)	DX 34 Wheeler/BCR, B; Scott/BCR, B	

[1]NIOSH (the National Institute of Occupational Safety and Health) is the federal government agency which certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as A-readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as B-readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
2/21/95	DX 65 Sargent/BCR, B (1/0, s/s)		DX 60, 66 Ramakrishnan/BCR, A (Significant chronic interstitial fibrosis) DX 74 Spitz/BCR, B, Wiot/BCR, B (Unreadable)
3/22/95	DX 60 Forehand/B (1/0,s/p)		
9/6/95	DX 72 Sargent/B (1/1, q/q)	DX 75 Spitz/BCR, B	

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. The quality standards for pulmonary function studies performed before January 19, 2001, are found at 20 CFR § 718.103 (2000). The standards require that the studies be accompanied by two or three tracings of each test performed. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	MVV Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Ratio	Compre- hension/ Cooper- ation	Qual- ify	Physician Impression
DX 33 9/16/87 Byers	59 69"	1.50		2.48	61%	Good	No	Mild to moderate restrictive and severe obstructive ventilatory process
DX 27 10/7/87 Parantha- man	59 66.5"[2]	1.84 2.05	83 93	3.11 3.05	59% 67%	Good	No No	Moderate obstructive ventilatory abnormality. Minimal change during bronchodilator study
DX 27 6/9/88 Endres- Bercher	60 66"	2.65	106	3.39	78%	Good	No	Normal

[2]The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). Mr. Chester testified that he is 5'9" tall. 1991 Tr. at 11. As there is a variance of 4" in his recorded height, from 65" to 69", I have taken the height found by Judge Teitler (67.3") in determining whether the studies qualify to show disability under the regulations. See the additional discussion below at pp. 23-24.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	MVV Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Ratio	Compre- hension/ Cooper- ation	Qual- ify	Physician Impression
DX 15 7/17/90 Nash	62 68"	2.05	50.8	3.14	65%	Good	No[3]	Qualifies for disability (but based on wrong standard, see discussion below at p. 23)
DX 12 8/15/90 Parantha- man	62 67"	2.24 2.54	89 85	3.74 3.69	60% 69%	Good	No No	Mild airway obstruction. Some improvement postbroncho-dilator.
DX 64 3/22/95 Forehand	66 65"	1.66 1.80	57	2.60 2.56	64% 70%	Good	Yes[4] No	Irreversible obstructive ventilatory pattern.

[3]Dr. Fino found the study to be invalid due to suboptimal patient effort. EX 1.

[4]Dr. Michos determined the test to be invalid due to a greater than 5% variation between the two best FVC and FEV_1 values. DX 64; *see* Section (2)(G) of Appendix B to 29 CFR Part 718. Dr. Fino, without explanation, also stated that it was invalid. EX 1.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	MVV Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Ratio	Compre- hension/ Cooper- ation	Qual- ify	Physician Impression
DX 72 9/6/95 Sargent	67 66"	1.69 2.28	69	2.48 3.21	68% 71%		Yes[5] No	Moderate reversible ventilatory impairment not consistent with CWP, consistent with asthma.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies performed before January 19, 2001, are found at 20 CFR § 718.105 (2000). The following chart summarizes the arterial blood gas studies available in connection with the current claim. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2000).

Exhibit Number	Date	Physician	PCO_2 at rest exercise	PO_2 at rest exercise	Qualify	Physician Impression
DX 33	9/16/87	Byers	35.6	71.1	No	Mild hypoxemia
DX 27	10/7/87	Paranthaman	35.3 32.1	64.8 76.0	No No	Moderate hypoxemia at rest.

[5]Without explanation, Dr. Fino concluded that the September 6, 1995 pre-bronchodilator test was technically invalid, and that the post-bronchodilator study was entirely within normal limits. EX 1.

Exhibit Number	Date	Physician	PCO_2 at rest exercise	PO_2 at rest exercise	Qualify	Physician Impression
DX 27	6/9/88	Bercher	35.2	75.7	No	Mild hypoxemia
DX 15	7/17/90	Nash	37.3	75.9	No	
DX 13	8/15/90	Paranthaman	35.9	87.4	No	Normal
DX 64	3/22/95	Forehand	35 33	60 69	Yes[6] No	Resting hypoxemia with some improvement during exercise.
DX 72	9/6/95	Sargent	35.7	78.7	No	

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2001). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2001). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2001). With certain specified exceptions, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2001). Quality standards for reports of physical examinations performed before January 19, 2001, are found at 20 CFR § 718.104 (2000). The record contains the following medical opinions relating to the current claim.

[6]Dr. Michos determined that the study was valid. DX 64.

Dr. John G. Byers, Jr., interviewed and examined the claimant on September 16, 1987. The claimant was still working in the coal mines at the time. Symptoms were that:

> [He] can walk 600 to 700 feet in 60 inch coal if he stops on several occasions. He can climb one flight of steps. He has intermittent shortness of breath on most nights. He will awaken wheezing. He denies snoring or apnea. He has been wheezing for about ten years and notes that this symptom is worse at night. It is also worse with exertion and when in contact with cigarette smoke. Strong odors or perfumes and contact with cold air do not precipitate wheezing. Wheezing will improve when he mobilizes sputum. He has coughed daily for many years, especially at night. . . .

Examination revealed decreased inspiratory breath sounds but of fair quality. Forced expiratory maneuver revealed early airway shut down with distant musical wheezing. Forced expiratory volumes were low and this was consistent with a significant obstructive ventilatory defect. An electrocardiogram showed possible mild sinus bradycardia. A pulmonary function study revealed a moderate restrictive and severe obstructive ventilatory defect. A post-bronchodilator study could not be obtained because the claimant became dizzy from the bronchodilator. An arterial blood gas test showed mild hypoxemia. An x-ray was positive for pneumoconiosis, 2/1. Dr. Byers concluded that:

> Mr. Chester has or may have several medical impairments. He has exogenous obesity with probable muscular detraining to some extent. There is evidence for heart disease with cardiomegaly and history of chest pain suggestive of angina pectoris. There is a long history of respiratory symptoms with history of chronic tobacco abuse, suggesting at least an element of tobacco induced lung disease. There are gastrointestinal symptoms with heartburn and eructation possibly related to hiatal hernia and to use or abuse of chewing tobacco. There is history of some form of inflammatory process in the knees requiring steroid injection. No physical abnormalities were noted to confirm this problem.
>
> There is a definite respiratory impairment. There is mild hypoxemia with a moderate restrictive and moderate to moderately severe obstructive process which is evident both on pulmonary function testing and on physical examination. This patient's exercise tolerance by his history is actually quite good for the amount of impairment measured and under the circumstances of his obesity and probable underlying organic heart disease.
>
> Based on the radiologic, physiologic and physical examination findings, this patient would appear to have moderately severe respiratory impairment which may be somewhat influenced by underlying heart disease. His impairment would cause significant shortness of breath with sustained mild to moderate exertion such as walking, even on level ground. I am frankly surprised that he is able to work with 150 lb. "curtains" in the coal mine and I suspect that he has considerable help when engaged in this endeavor. I can not state that his impairment is disabling because he does continue to work with at least some effectiveness.

> The findings . . . are consistent with coal worker's pneumoconiosis which would appear to be at least a contributing cause to the patient's respiratory impairment. Other contributing causes would include chronic pulmonary damage due to chronic tobacco abuse, possible chronic recurrent aspiration of small amounts of gastric contents associated with hiatal hernia with consequent progressive chronic lung damage, and dyspnea and chest pain due to organic heart disease which would result in further exercise intolerance.
>
> Although Mr. Chester continues to work, I would frankly not recommend that he continue working in an underground coal mine. I would also recommend that his personal physician consider CT scanning of the chest to rule out right hilar mass. Further work up for the possibility of angina pectoris (to include an exercise stress test, possibly with thallium scanning) would be indicated.

DX 33.

Dr. S. K. Paranthaman interviewed and examined the claimant on October 7, 1987. The claimant was still working. Examination revealed decreased breath sounds and bilateral fine basal rales. An electrocardiogram was normal. An x-ray was positive for pneumoconiosis, 1/0. An arterial blood gas test revealed moderate hypoxemia at rest, improving with exercise. A pulmonary function study showed a moderate obstructive ventilatory abnormality, with minimal change post-bronchodilator. Dr. Paranthaman diagnosed simple coal workers' pneumoconiosis and hypertension. He recommended repeating the arterial blood gas at rest in 3-6 months because the current value was close to disability level. DX 27.

Dr. Greg J. Endres-Bercher interviewed and examined the claimant on June 9, 1988. The claimant was still working at the time. Examination of the chest was unremarkable. An x-ray was negative for pneumoconiosis, 0/1. A pulmonary function study was normal. Lung volume studies were invalid. An arterial blood gas test revealed mild hypocarbia with mild hypoxemia at rest. An electrocardiogram was normal, as was a blood count. Dr. Bercher concluded that:

> The patient has no evidence for coal worker's pneumoconiosis or any other type of disabling respiratory impairment. Chest x-ray was a poor inspiratory film which can result in the vascular prominence and relative enlargement of the heart as seen on today's x-ray. The patient has no clinical signs of any cardiac decompensation and his EKG is within normal limits. Spirometry is within normal limits and the diffusion capacity is also within normal limits indicating no impediment to the transfer of oxygen from air to blood. From a respiratory viewpoint he does not have coal worker's pneumoconiosis or any other type of disabling respiratory impairment and retains sufficient lung capacity to carry on his present coal mining duties or any other type of strenuous activity.

Dr. Bercher is board-certified in internal medicine. DX 27.

Dr. John H. Scott reviewed the medical records and issued a report on April 9, 1990, with the most recent medical data being from 1988. He stated that:

> I find no objective evidence of coal workers' pneumoconiosis. Symptoms are consistent with chronic bronchitis without airway obstruction at the time of the most recent examination. There is an extensive history of cigarette smoking, in excess of 20 pack-years, and such a history of cigarette smoking correlates strongly with development of chronic bronchitis with ventilation perfusion abnormalities in the lungs of cigarette smokers such as Mr. Chester. The various expert B-readers who reviewed the available chest X-rays from each examination found no evidence of pneumoconiosis on chest X-ray.
>
> Mr. Chester was found to be overweight on physical evaluation, and hypertension was noted also. Obesity may cause symptoms of exertional dyspnea due to the increased work of breathing when exercising. Hypertension may cause cardiac dysfunction sufficient to cause symptoms of exertional dyspnea due to cardiac abnormality.
>
> The most recent pulmonary function studies done in 1988, at the time of the evaluation by Dr. Endres-Bercher, are normal and show no evidence of pulmonary impairment. From the standpoint of his respiratory system, Mr. Chester is capable of performing the duties of his work as a miner, or work requiring similar effort.

Dr. Scott is board-certified in internal and pulmonary medicine. DX 27.

The claimant was examined and interviewed by Dr. Arthur J. Nash on July 17, 1990. The claimant was planning to quit work in two weeks due to his shortness of breath and arthritis. Examination revealed moderate dyspnea. An x-ray was positive for pneumoconiosis, 1/1. A pulmonary function test and an arterial blood gas test were obtained. As to the former, Dr. Nash commented that:

> Comparing the pulmonary function studies with the disability standards under the law put out by the U.S. Department of Labor, Form CM-1000 e, January, 1979; their interim disability standards on the ventilatory study show that if the patient is 5'8", or less in height, which this man is, that his FEV1 should be 2.4, or less. This man's FEV1 is only 2.05. The same set of rules states that his MVV should be 96, or less. This man's MVV is only 50.8. Therefore, under this particular set of rules he does qualify for disability.

Dr. Nash diagnosed osteoarthritis, mild exogenous obesity, arteriosclerotic heart disease with mild congestive failure, chronic obstructive lung disease, and coal workers' pneumoconiosis 1/1. He stated that:

> It is my opinion that this man after having worked 43 years underground in the coal

mines and being exposed to rock, sand and coal dust during all this time is totally and permanently disabled for all work, especially heavy work in a dusty environment like the coal mines.

It is also my opinion that nearly all of his pulmonary problems arose as a result of working this length of time in the mines.

It is further my opinion that a return to this type of work would be extremely hazardous to his health and dangerous to his life.

DX 15.

Dr. S. K. Paranthaman interviewed and examined the claimant on August 15, 1990. Examination of the chest was unremarkable. An x-ray was positive for pneumoconiosis, 1/0. A pulmonary function study and arterial blood gas test were obtained. An electrocardiogram revealed nonspecific ST-T wave changes. Dr. Paranthaman diagnosed coal workers' pneumoconiosis, 1/0, due to coal mine employment; chronic bronchitis due to the combined effects of coal dust exposure and cigarette smoking; and hypertension. He concluded that "[t]his degree of impairment does not prevent him from doing the job of a coal miner." DX 14.

Dr. J. Randolph Forehand examined and interviewed the claimant on March 22, 1995. The claimant's symptoms were:

For the last ten years he has developed progressively worsening shortness of breath. This shortness of breath is exertional and is to the point that he cannot mow his yard or walk in the mall without having to stop and rest. At night he lies on his side using one pillow. His shortness of breath during the day is associated with a cough productive of 2-3 teaspoonfuls a day of greenish, non-bloody phlegm. His cough sometimes interferes with sleep at night and also appears when he gets hot. He sometimes awakens in the night wheezing and feeling short of breath and tight in his chest. His symptoms occur daily on a perennial basis without seasonal or environmental variability. He did not have a similar condition during childhood. Exposure to damp moldy areas and weather changes make him feel worse.

Examination revealed scattered mid inspiratory crackles at the bases, principally on the left. An x-ray was positive for pneumoconiosis, 1/0. A pulmonary function study showed a mild to moderate irreversible obstructive ventilatory pattern with normal gas exchange. An electrocardiogram was normal. Dr. Forehand diagnosed coal workers' pneumoconiosis with air flow limitation, and chronic bronchitis from cigarette smoking. He stated that:

Working 21 years in a poorly controlled dusty environment will lead to coal workers' pneumoconiosis with respiratory impairment. His on-going exposure has produced a mild to

moderately severe obstructive ventilatory impairment. There is also a respiratory impairment of gas exchange nature at rest with modest improvement during exercise. Although disputed by some I believe Mr. Emerson's pattern of respiratory impairment arose in part from his coal mine employment. This opinion is based on personal experience examining over 900 coal miners claiming respiratory disability and from a review of the current medical literature on the subject. Cigarette smoking also causes a similar respiratory impairment but 10 years would not be the sole cause of a respiratory impairment to the degree seen here. Obstructive ventilatory impairments are made worse by on-going exposure to dusty environments. Returning to Mr. Emerson's last coal mining job would significantly aggravate his respiratory impairment and complaints of shortness of breath. This would in turn prevent him from completing his job on a day to day basis in a satisfactory manner.

DX 60.

Dr. J. Dale Sargent examined and interviewed the claimant on September 6 and 27, 1995. A pulmonary function study revealed a moderate obstructive impairment that resolved completely after bronchodilator. There was air trapping and hyperinflation with normal diffusing capacity.[7] An x-ray was positive for pneumoconiosis, 1/1. An electrocardiogram was normal, as was a resting arterial blood gas test. Dr. Sargent concluded that:

Mr. Chester is suffering from simple coal worker's pneumoconiosis. This determination is based on his positive x-ray.

He is also suffering from a moderate completely reversible ventilatory impairment. This type of ventilatory impairment is not consistent with impairment due to coal worker's pneumoconiosis, and in fact, it would be highly unusual for simple coal worker's pneumoconiosis of major category I to cause a measurable ventilatory impairment.

If the simple coal worker's pneumoconiosis were causing an impairment it would be an impairment which did not improve with bronchodilator and it would be a mixed obstructive and restrictive impairment, which would be associated with obstruction on spirometry, but also associated with less than normal total lung capacity and residual volume. In Mr. Chester's case, he has a purely obstructive impairment that resolves completely after bronchodilator which is inconsistent with impairment due to coal dust exposure, but is completely consistent with impairment due to asthma.

Mr. Chester did give me a history today of wheezing, especially at night and with

[7]Although his cover letter stated that there was normal diffusing capacity, the pulmonary function report noted decreased diffusing capacity.

exposure to rag weed, which is consistent with his history as with his pulmonary function tests showing asthma. He is not on any bronchodilator medicines and his respiratory status would probably improve significantly where (sic) he placed on chronic bronchodilator therapy.

Even pre-bronchodilator, however, his ventilatory abnormalities are not of sufficient magnitude to keep him from doing his last job as a general inside man as he described that to me. Also, I would anticipate significant improvement in his baseline (pre-bronchodilator) ventilatory studies where (sic) he placed on regular dilator medicines.

DX 72.

On December 6, 1995, Dr. John A. Michos wrote that:

Based on the extensive medical evidence provided, it is my reasoned medical opinion that Mr. Chester has radiographic evidence of a simple C[oal] W[orkers'] P[neumoconiosis] brought on by an approximate 39 year history of C[oal] M[ine]E[mployment], which ended in August of 1990. Additionally, Mr. Chester gives a history and has studies consistent with asthma and not CWP. The improvement in oxygenation seen on numerous ABG's as well as the significant improvement with bronchodilators seen on the PFT dated 9/6/95 speak against a total respiratory disability.

Finally, it is my opinion that the miner has the respiratory capacity to perform his last C[oal] M[ine] E[mployment] and would also subjectively improve if placed on a regular inhaled bronchodilator regime.

DX 76.

Dr. Gregory J. Fino, who is board-certified in internal and pulmonary medicine, reviewed the medical records and issued a report on December 7, 1996. He concluded that the claimant does not have an occupationally acquired pulmonary condition arising out of coal mine dust exposure, based on the following:

1. The majority of the x-ray readings are negative for pneumoconiosis.

2. The acceptable spirometric evaluations are normal with no obstruction, restriction, or ventilatory impairment.

3. Diffusing capacity values are normal ruling out the presence of clinically significant pulmonary fibrosis. Pneumoconiosis is, of course, an example of a pulmonary fibrosis.

4. This man does not experience hypoxia with exercise, thus indicating no oxygen

transfer impairment.

5. Lung volumes are a measure of whether the lung is of normal consistency, whether it is over-inflated, or whether it is under-inflated. Over-inflated conditions are due to obstructive lung disease. Under-inflated conditions are due to contraction due to fibrotic scarring as is seen in pulmonary fibrosis. This man has normal lung volumes. There is no over-distention or over-inflation consistent with an obstructive condition nor is there any evidence of under-inflation due to fibrosis of which pneumoconiosis is an example.

Some of the lung function studies have been interpreted as showing obstruction. I do not agree and believe that these showed "obstruction" because of invalid efforts on the part of the patient. I would note, however, that the type of obstruction that is noted here would not be consistent with a coal mine dust-related pulmonary condition. The spirometric evaluations that have been performed show an obstructive ventilatory abnormality based on the reduction in the FEV1/FVC ratio. This obstructive ventilatory abnormality has occurred in the absence of any interstitial abnormality. In addition, the obstruction shows involvement in the small airways. Large airway flow is measured by the FEV1 and FEV1/FVC ratio. Small airway flow is measured by the FEF 25-75. On a proportional basis, the small airway flow is more reduced than the large airway flow. This type of finding is not consistent with a coal dust related condition but is consistent with conditions such as cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma. Minimal obstructive lung disease has been described in working coal miners and has been called industrial bronchitis. This condition is characterized by cough and mucous production plus minimal decreases in the FEV1 in some miners. Industrial bronchitis resolves within six months of leaving the mines. Obstructive lung disease may also arise from coal workers' pneumoconiosis when significant fibrosis is present. The fibrosis results in the obstruction. In this case, although obstruction can be seen in coal workers' pneumoconiosis, the obstruction is unrelated to coal mine dust exposure.

What I see in these pulmonary function studies that suggested obstruction was what, at times, was interpreted as showing significant improvement following bronchodilators. Such reversibility is not consistent with a coal mine dust-related pulmonary condition. Reversibility following bronchodilators implies that the cause of the obstruction is not fixed and permanent. Certainly, pneumoconiosis is a fixed condition. Because it is fixed, bronchodilator medication would be of no benefit. One cannot improve on an abnormality caused by coal workers' pneumoconiosis. Hence, improvement following bronchodilators showing reversibility to the overall pulmonary impairment is clearly evidence of a non-occupationally acquired pulmonary condition causing the obstruction.

I believe that the improvement following bronchodilators is actually not a true bronchodilator response but is in fact a better effort by the patient.

However, even if I were to assume that simple coal workers' pneumoconiosis was present and I was to assume that he had an obstructive abnormality that improved back into the normal range with bronchodilators, it would still be my opinion that this man is not disabled. My reasons are as follows:

1. He does indeed have the ventilatory capacity to perform heavy labor in the mines considering the normal FVC, FEV1, and MVV values.

2. This man has a normal diffusing capacity which rules out the presence of clinically significant lung destruction secondary to pulmonary fibrosis and/or pulmonary emphysema. Simple coal workers' pneumoconiosis is an example of a pulmonary fibrosis.

3. He does not show a decrease in the pO2 with exercise.

Coal workers' pneumoconiosis is an interstitial pulmonary condition. As such, it would manifest itself as an interstitial abnormality. An interstitial pulmonary condition is caused by pulmonary fibrosis in the inerstitium of the lung. That is the portion of the lung in between the air sacs and the breathing tubes. In the interstitial pulmonary conditions, the type of respiratory impairment that develops is different than the type of respiratory impairment in an obstructive defect. . . .

EX 1.

Existence of Pneumoconiosis

The Board's remand included an instruction that I determine whether Claimant has met his burden to establish the existence of pneumoconiosis based on all the types of relevant evidence of record. The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) *Clinical Pneumoconiosis.* "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis.* "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2001). In this case, Mr. Chester's medical records indicate that he has been diagnosed with pneumoconiosis, as well as chronic bronchitis, chronic obstructive pulmonary disease and emphysema, which can also be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

20 CFR § 718.202(a) (2001), provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Chester has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, he filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v.*

Director, OWCP, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); Stanford *v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, above at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the 10 available x-rays taken since 1987 in this case, 9 have been read by some or all reviewers to be positive for pneumoconiosis, and only one to be negative by all readers who found the quality of the x-ray sufficient for it to be read. For cases with conflicting x-ray evidence, the Regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2001); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984).

A letter from the Health and Human Services Department found in DX 27 refers to a "category 1" classification of a January 1987 x-ray, but there is little information about the x-ray, and none about the qualifications of its interpreter. Thus I will focus on the x-rays taken from March 1987 forward. The March 31, 1987, x-ray was read as negative by three B-readers, and unreadable by two others. I find this x-ray to be negative.

The September 16, 1987, x-ray was read as positive by an A-Reader, but negative by two dually qualified board certified radiologists and B-readers. Similarly, x-rays taken on October 7, 1987 and June 9, 1988, were each read by a B-reader to be positive, but negative by three or four dually qualified readers. These, too, I find to be negative.

` The other five x-rays taken in 1990 and 1995, however, tip the weight of the x-ray evidence in favor of a finding that the claimant has established the existence of pneumoconiosis, both because they are more recent, and because the majority of physicians are highly qualified and have read them to be positive. In addition to the positive readings by B-readers and dually qualified readers, there is one reading by a radiologist who did not specifically classify or refer to pneumoconiosis, but noted significant chronic interstitial fibrosis, which I find to be a positive reading as well, as interstitial fibrosis falls within the definition of legal pneumoconiosis. The positive x-ray evidence is further supported by the opinions of Dr. Byers, Dr. Nash, Dr. Paranthaman, Dr. Forehand and Dr. Sargent, all of whom examined Mr. Chester and diagnosed simple pneumoconiosis.

The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). Two of the three doctors who examined the Mr. Chester before 1990, and all of the doctors who examined him in 1990 or later, diagnosed simple pneumoconiosis. Only Dr. Endres-Bercher found no evidence of pneumoconiosis, and as his examination took place in 1988, it is entitled to less weight than the later examinations. Of the doctors who reviewed medical records but did not examine the claimant, Dr.Scott had no medical data after 1988, and thus his opinion is also entitled to less weight. Dr. Michos concurred that there was radiographic evidence of pneumoconiosis. Dr. Fino opined that Mr. Chester does not have pneumoconiosis. His opinion that the "majority" of x-ray readings are negative failed to address the fact that the majority of the recent readings are positive. Furthermore, his opinion is outweighed by those of the physicians who examined the claimant. Thus I give his opinion on this issue little weight.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the Regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2001). Mr. Chester was employed as a miner for at least 32 years, and therefore is entitled to the presumption. I find that his coal mine employment caused him to develop pneumoconiosis.

Total Disability

The pivotal issue is whether the claimant has established that he is totally disabled from a pulmonary or respiratory standpoint. If so, the claimant has shown a mistake of fact in, or change of conditions since, Judge Teitler's 1994 Decision and Order, pursuant to 20 CFR § 725.310 (2000); and he has also shown a material change in conditions since the denial of his previous claim in 1984, pursuant to 20 CFR § 725.309(d) (2000). A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2001), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2001). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b)(2) (formerly 204(c)) and (d) (2001). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2001); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that Mr. Chester suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions.

When Judge Teitler issued his decision denying benefits on remand, the most recent medical evidence dated from 1990. As the evidence stood in 1990, there were no qualifying pulmonary function or arterial blood gas tests. The claimant was still working in the mines until July 30, 1990. Of the doctors who had examined Mr. Chester or reviewed his records, only Dr. Nash was of the opinion that he was totally disabled. Dr. Nash's opinion was based on his erroneous finding that the pulmonary function studies revealed qualifying values. Review of the rules shows that the values were qualifying under Part 727, but not Part 718. However, this claim comes under Part 718. Furthermore, Judge Teitler found that Dr. Nash's opinion was not well-reasoned because of inconsistency between the findings and the objective testing, and that Dr. Nash's credibility was affected by his legal history. Nor was Dr. Nash board certified as were doctors who opined that Mr. Chester was not disabled. Having conducted an independent evaluation of the evidence, I see no basis to conclude that Judge Teitler made a mistake in a determination of material fact when he concluded that Mr. Chester was not disabled as of 1990. Indeed, the available evidence supports the conclusion that although pneumoconiosis was present in 1990, the claimant was not yet disabled, for the reasons stated by Judge Teitler. Pneumoconiosis being a progressive disease, however, the issue remains whether Mr. Chester's condition changed between 1990 and 1995, when the next medical evidence is available in the record.

In his analysis of the pulmonary function studies up to 1990 under §718.204(c)(1), Judge Teitler found that the claimant's height was 67.3 inches. DX 43 at p. 8. Judge Teitler did not explain

his finding, but it happens to be the average of the seven measurements which were before him and noted: 68, 66.5, 69, 66.5, 66, 68, and 67 inches. That finding was unchallenged on appeal before the Board. DX 52.

Judge Rosenzweig, who reviewed all of the pulmonary function studies, and without addressing the claimant's height or providing an explanation, concluded that "[n]one of these studies produced values which would support a finding of total disability . . ." (May 19, 1998 Decision and Order at p. 10). That finding was not addressed by the Board. (September 30, 1999 Decision and Order; July 31, 2001 Decision and Order). However, at 67.3 inches, the prebronchodilator studies of March 22 and September 6, 1995 did produce qualifying values. At 66.9 inches (which would be the average adding in the two measurements from 1995), the prebronchodilator study of March 22, 1995 is still qualifying, and the September 6, 1995 has a qualifying FEV1 value but a non-qualifying MVV value.

While the March 22, 1995 study was found to be invalid by Dr. Michos, who provided a credible explanation (*see* DX 64), the September 6, 1995 study was not similarly invalidated. Dr. Sargent did not invalidate that study, which he obtained; the computer printout shows only the FVC to be without the 95% confidence level; the study is qualifying based on the FEV1 and MVV values; and Dr. Fino's conclusory statement of invalidity (*see* EX1) is insufficient to overcome the presumption of validity. *See Brinkley v. Peabody Coal Co.*, 14 B.L.R. 1-147 (1990) (if the administrative law judge credits a consultant's opinion over one who actually observed the test, a rationale must be provided); *Gabino v. Director, OWCP*, 6 B.L.R. 1-134 (1983) (a consulting physician who merely places a checkmark in a box indicating "poor or unacceptable technique," without explanation, has not provided sufficient evidence to support his or her rejection of the study); *Defore v. Alabama By-Products Corp.*, 12 B.L.R. 1-27 (1988) (a party challenging the admission of objective medical evidence must specify how the evidence fails to conform to the quality standards, and how this defect or omission renders the study unreliable).

While the preponderance of this evidence may still be that the studies do not establish qualifying values under § 718.204(c)(1), the evidence nevertheless shows that the claimant's pulmonary status is impaired. This will be further addressed below.

As to the blood gas study and medical opinions, the Board, in its most recent decision, held that:

> . . . The administrative law judge properly characterized Dr. Forehand's "resting" blood gas study as producing qualifying results. Decision and Order Awarding Benefits on Remand at 5, 6. The administrative law judge properly relied on the recency of Dr. Forehand's March 1995 medical opinion, including its underlying supporting objective evidence, in finding that the claimant has established on modification that he is now totally disabled due to a respiratory or pulmonary impairment. 20 CFR §725.310 (2000); *see generally Adkins v. Director, OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th

Cir. 1992). In this regard, the administrative law judge determined that the fact that Dr. Sargent examined claimant six months after Dr. Forehand examined claimant did not render Dr. Sargent's opinion more recent as these examinations were close in time and thus contemporaneous. In crediting Dr. Forehand's opinion, the administrative law judge properly accorded less weight to the older evidence of record which she found was generated a significant number of years prior to Dr. Forehand's report and prior to claimant's retirement from the coal mines in July 1990. . . . *Id.*

. . . Employer also contends that the administrative law judge erred in her analysis of "the importance and meaning" of Dr. Forehand's narrative report. Specifically, employer submits that the administrative law judge "got it right the first time" when, in her May 1998 Decision and Order, she discredited Dr. Forehand's opinion. Employer offers several reasons in support of its position that Dr. Forehand's opinion is not credible and is not sufficient to establish that claimant is totally disabled due to pneumoconiosis. Employer's Brief at 12-14.

It is within the province of the administrative law judge as factfinder to determine the credibility of the medical evidence. *Lane v. Union Carbide Corp.*, 105 F.3d 166, 21 B.L.R. 2-34 (4th Cir. 1997); *Worley v. Blue Diamond Coal Co.*, 12 B.L.R. 1-20 (1988). In the instant case, the administrative law judge acted within her discretion in according great weight to Dr. Forehand's opinion based on her finding that Dr. Forehand provided a thorough examination of claimant, including work, family and medical histories in analyzing claimant's medical status. Decision and Order at 5; *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(*en banc*); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). . . .

Emerson Chester v. Hi-Top Coal Company, et al., BRB No. 00-1000 BLA (July 31, 2001) at pp. 4-5 (footnote omitted).[8] Thus, the Board upheld the findings that Dr. Forehand concluded that the

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[8] In her May 19, 1998 Decision and Order, Judge Rosenzweig found that:

While Dr. Forehand speaks of a mild to moderately severe impairment, he never states that Claimant does not have the respiratory capacity to perform his last coal mine job. Indeed, he states only that if Claimant were to return to work, the environment would aggravate his impairment and increase his complaints of shortness of breath, but there is no statement that Claimant would not be able to perform the work because his pulmonary functional capacity would not support such a degree of labor.

Emerson Chester v. Hi-Top Coal Company, et al., 96-BLA-1075 (May 19, 1998) at p. 12.

claimant was totally disabled, and that his opinion was entitled to great weight. The Board also affirmed the finding that Dr. Michos's opinion was entitled to no weight due to his failure to identify the medical evidence he reviewed. However, the Board vacated the ultimate finding of total disability under 20 CFR § 718.204(c) (with its vacating of the finding under 20 CFR § 725.310) due to errors otherwise found in the weighing of the medical opinions of Dr. Sargent and Dr. Fino.

The relevant medical evidence as to whether the claimant has established that he is now disabled includes the 1995 pulmonary function and arterial blood tests, and the opinions of Drs. Forehand, Sargent, Michos and Fino. I concur with Judge Rosenzweig's finding, upheld by the Board, that Drs. Forehand's and Sargent's examinations conducted within six months of each other should be considered contemporaneous.

Dr. Forehand concluded that the claimant had a "mild to moderate" impairment based on the pulmonary function study he obtained, and a respiratory impairment of gas exchange at rest "with modest improvement during exercise." He said, in effect, that Mr. Chester could not return to work in a dusty environment which would make his impairment worse. While Dr. Forehand's pulmonary function study was invalidated, Dr. Sargent's subsequent valid study nevertheless shows that the claimant has a "moderate" impairment, as described by Dr. Sargent as well as Dr. Forehand. In addition, Dr. Forehand's qualifying resting blood gas study was deemed acceptable by Dr. Michos. I concur with Judge Rosenzweig's findings, upheld by the Board, that Dr. Forehand's thorough examination, including work, family and medical histories, together with the test results, support his opinion that Mr. Chester is unable to return to work in the mines, which is therefore entitled to great weight. A medical opinion better supported by the objective medical evidence of record is entitled to

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In her June 22, 2000 Decision and Order, Judge Rosenzweig found that:

> [I]n addition to Dr. Forehand's thorough examination of the Claimant, including his work, family and medical histories, and the qualifying-and acceptable, *per* Dr. Michos-resting blood gas study, a review of Dr. Forehand's analysis of Claimant's medical status reflects that Dr. Forehand did not solely state that Claimant's continued work in the mines would cause aggravation of his respiratory condition and thus his complaints related thereto; he also stated that the significantly aggravated respiratory impairment and the complaints of shortness of breath, " . . . would, in turn, prevent him from completing his job on a day to day basis in a satisfactory manner." DX 60. I find that Dr. Forehand's statement herein, as supported by his examination findings, constitutes a determination of total disability due to pneumoconiosis, and further, that my previous and truncated analysis of his report was in error. . . .

Emerson Chester v. Hi-Top Coal Company, et al., 96-BLA-1075 (June 22, 2000) at p. 5. In my view, Judge Rosenzweig got it right the second time.

more weight. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n.1 (1986). Dr. Forehand's opinion is the best-reasoned and most consistent with the evidence as a whole.

I also concur with Judge Rosenzweig's conclusion, upheld by the Board, that Dr. Michos failed to fully identify the evidence he relied upon in reaching his conclusions to the contrary and therefore also assign his opinion no weight. A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182, 1-1184 (1984).

Examining physician, Dr. Sargent, and reviewing physician, Dr. Fino, concluded that the recent studies and examinations do not evidence total disability. However, neither opinion acknowledges the qualifying or close-to-qualifying values of the pulmonary function study Dr. Sargent obtained. Dr. Fino's description of the claimant's pulmonary status as "normal," like his conclusion that Mr. Chester does not have pneumoconiosis, is an interpretation not supported by the evidence of record. Neither Dr. Fino nor Dr. Sargent acknowledges the decreased diffusion capacity reflected on Dr. Sargent's test report. The studies do show impairment, regardless of any dispute as to cause. Moreover, both Dr. Fino and Dr. Sargent apply a narrow interpretation of the term "pneumoconiosis" which is not consistent with the broad definition of legal pneumoconiosis contained in the case law and regulations. No matter how many words he uses to cushion his opinion, Dr. Fino clearly equates "pneumoconiosis" only with pulmonary fibrosis. Though he allows for temporary bouts of industrial bronchitis, Dr. Fino has not accepted the broad definition of pneumoconiosis under the Act, which covers conditions that do not involve fibrotic reaction of the lung tissue. Similarly, Dr. Sargent states that an impairment from simple pneumoconiosis would be a mixed obstructive and restrictive impairment, a reference to clinical, rather than legal, pneumoconiosis. Furthermore, neither Dr. Fino nor Dr. Sargent address whether there may be an interplay or aggravating effect of exposure to coal dust and Mr. Chester's diagnosed conditions, including pneumoconiosis, asthma and chronic bronchitis. Because their opinions are not as well reasoned or consistent with the evidence as a whole, I give their opinions less weight than Dr. Forehand's.

I find that total disability is established under 20 CFR §§ 718.204(b) (2001), as of March 1, 1995, the month Dr. Forehand examined the claimant. Accordingly, the claimant has shown a change in conditions as a basis for modification of the denial by Judge Teitler under 20 CFR § 725.310 (2000). In addition, the claimant has also shown a change in conditions since the denial of his previous claim under 20 CFR § 725.309 (2000).

Causation of Total Disability

The Board has held that §718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). The Fourth Circuit requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co.*, 917 F. 2d 790, 791-792 (4th Cir. 1990). A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory

or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2001); *Hobbs*, 917 F.2d at 792; *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990). Dr. Forehand's opinion that the claimant's "pattern of respiratory impairment arose in part from his coal mine employment" establishes that pneumoconiosis is a contributing cause to Mr. Chester's total disability. The claimant has met his burden.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has met his burden to establish that there has been a change in conditions, in that he is totally disabled due to pneumoconiosis. He is therefore entitled to benefits under the Act.

ATTORNEY FEES

The Regulations address attorney's fees at 20 CFR §§ 725.362, 365 and 366 (2001). Claimant's attorney has not yet filed an application for attorney's fees. Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The parties have ten days following service of the application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The request for modification filed by Emerson Chester on April 23, 1995, is hereby GRANTED. IT IS THEREFORE ORDERED, the Employer shall pay benefits to the Claimant commencing March 1, 1995, augmented by his spouse, Wanda Chester.

A
Alice M. Craft
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2001), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.